UTAH DEPARTMENT OF HEALTH

CHILDREN'S HEARING AID PILOT PROGRAM (CHAPP) UCA 26-10-11
PAYMENT REQUEST COVER SHEET

CHILD

Child's Assigned CHAPP #	Managing Audiologist Name	Clinic	Date

REQUESTING PAYEE (who check should be made out to and where it should be sent)

Agency/Clinic		Dept (Attn:)		
Address		City	State	Zip
Contact Person for Questions	Phone	Email		

Documentation must be submitted within 30 days of fitting to:

Utah Department of Health
Children's Hearing and Speech Services ATTN: CHAPP
PO Box 144620
Salt Lake City, Utah 84114-4620

For additional information, please contact:

Stephanie McVicar, AuD, CCC-A
(801) 584-8215

Reimbursement details:

☐ Hearing Aid invoice (MUST BE ATTACHED)	$
40% of Hearing Aid invoice amount =	$
☐ Reasonable and customary* fees *for hearing aid fitting and one year of follow-up services:* **(REAL-EAR MEASUREMENT FOR FITTING MUST BE ATTACHED)**	$
☐ Earmold invoice (MUST BE ATTACHED):	$
☐ Reasonable and customary* fees *for ear mold fitting:* **(*CLINIC HEARING AID/EARMOLD FEE PRICE SHEET MUST BE ATTACHED)**	$
TOTAL REQUESTED	$

As the managing audiologist, I certify that the documentation and request for payment represent accurate and appropriate services provided per UCA 26-10-11.

Managing Audiologist Signature	Date
CHAPP Authorized Signature	Date
Additional Information Required (for office use only)	

REV 7:04292014